MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05600

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 901 Glenwood St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 901 Glenwood St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Daniel Walter Abey

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Elizabeth Weber

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 29, 1882

8. AGE:	Years	Months	Days	If less than one day
	63	3	28	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Md.
(Town, county, and state)

10. Usual occupation: Moulder

11. Industry or business: W & G Taylor Tinplate Mill

FATHER
12. Name: John Abey
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Mary Mc Kenzie
15. Birthplace: W. Va.

16. Informant: Nicholas Abey

Address: 2 Glenwood St - Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 29 1945 (month) (day) (year)

Cemetery or crematory: Abey Cemetery

Location: Near Wiley Ford W. Va.

18. Funeral director: John J. Hafer

Address: Cumberland Md

19. June 28 19 45 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1945, at 12:05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1945, to June 27 1945, and that I last saw h... alive on June 26 1945.

	DURATION
Immediate cause of death: Bronchopneumonia	3 days
Due to: Bronchial Asthma	15 yrs
Due to: Cardiac Failure	4 hrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: M. R. Clemens M.D.
M. D. or other

Address: 32 Va Ave Date signed 6-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05601

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: 35. Years
Hospital, institution, or street address where death occurred: 113 W. Second St
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No.: 113 W. Second St (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Eliza Etta Albright

3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Thomas P. Albright
6.(c) If alive, give age: ... years
7. Birth date of deceased (mo., day, yr.): October 21, 1865

8. AGE:

Years	Months	Days	If less than one day
79	7	26	... hrs. ... min.

9. Birthplace: Terra Alta, Preston Co, W. Va. (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Own House

FATHER
12. Name: Hiram Dodge
13. Birthplace: Terra Alta, W. Va.

MOTHER
14. Maiden name: Unknown Beakley
15. Birthplace: Terra Alta, W. Va.

16. Informant: Mrs. Edgar J. Allen
Address: Ellerslie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/20/45 (month) (day) (year)
Cemetery or crematory: Greenmount Cemetery
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. June 20, 1945 (Date rec'd by registrar) Winter R. Frantz, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17, 1945, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1945, to June 17, 1945, and that I last saw her alive on June 16, 1945

		DURATION
Immediate cause of death	Chronic nephritis	6 yrs
	Chronic myocarditis	6 yrs
Due to	Secondary anemia	3 yrs
Due to	Arteriosclerosis	1½ yrs

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: H. C. Gleason MD M. D. or other
Address: 126 Greene St Cumberland, Md Date signed: 6/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B/C)

CERTIFICATE OF DEATH

15602

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 South Mechanic St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Ralph Allen

3.(b) Social Security Number 212-12-8359

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife May Owens

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb - 9 - 1887

8. AGE: Years	Months	Days	If less than one day
58	3	24	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Bartender

11. Industry or business Saloon

FATHER
12. Name John Allen
13. Birthplace West Va.

MOTHER
14. Maiden name Mary E. Flury
15. Birthplace Cumberland, Md.

16. Informant Mrs. J. M. Webber
Address Pittsburgh, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6 1945 (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. June 6 1945 Walter R. Krantz M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945 at 8 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1935 to June 3 1945 and that I last saw him alive on June 3 1945

Immediate cause of death	DURATION
Apoplexy	1 Wk.
Due to Hypertension	
Cerebral vascular	10 yrs.
Due to disease	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Lyle R. Eichart M.D.
M. D. or other

Address 36 Green St Date signed 6/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

05603

FILM No. G 95 JUN 19 1945

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State W. VA. County GRANT

City or town BAIRD
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS. ROSE ANTHONY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	W	WIDOW

6.(b) Name of husband or wife FRITZ ANTHONY

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCT. 3, 1880

8. AGE: Years	Months	Days	If less than one day
64 ~~65~~	9	3	..... hrs. ..... min.

9. Birthplace AUSTRIA
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Unknown

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace Germany

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 9 1945 (month) (day) (year)

Cemetery or crematory Baird Cem.

Location Baird, W. Va.

18. Funeral director O. F. Sharpless

Address Blaine, W. Va.

19. June 8, 1945 (Date rec'd by registrar) Winter R. Trantz, M.D. Registrar

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH JUNE 6 1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1945, to June 6 1945 and that I last saw h.. alive on June 6 1945

Immediate cause of death	DURATION
Shock - Carcinoma Esophagus	
Due to Stricture - of Esophagus	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Gall stones - Cholecystectomy Date of op. June 5

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. G. Grace M. D. or other

Address Cumberland Date signed June 7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

05604

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 years

Hospital, Institution, or street address where death occurred: Allegany Street

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Allegany Street

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Hugh Henry Atkinson

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Muir

6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): October 27, 1858

8. AGE: Years: 86 | Months: 7 | Days: 7 | If less than one day: ... hrs. ... min.

9. Birthplace: Toronto Canada (Town, county, and state)

10. Usual occupation: Store Manager Retired

11. Industry or business: Co Operative Store

FATHER — 12. Name: Hugh Atkinson

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Elizabeth Wallace

MOTHER — 15. Birthplace: Scotland

16. Informant: Mrs James Richmond

Address: Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing Md

19. June 5 1945 Dr. E. Dunigle Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4th 1945 at 1.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other

Address: Lonaconing, Md. Date signed June 5th 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. HAWKINS

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1178)

CERTIFICATE OF DEATH

★05605

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town BARTON
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MR. CONDA BARNES

3. (b) Social Security Number ?

4. Sex MALE

5. Color or race WHITE

6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) JANUARY 17, 1898

8. AGE: Years 47 Months 4 Days 12 If less than one day ... hrs. ... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation TIMBER LOGGER & TRUCKER

11. Industry or business

FATHER 12. Name SHERIDAN BARNES

13. Birthplace PENNSYLVANIA

MOTHER 14. Maiden name SHERA DEAL

15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof July 2 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laurel Hill

Location Moscow, Md.

18. Funeral director Ellsworth S. Boyl

Address Westernport, Md.

19. July 2, 19 45 Walter L. Franz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 29 19 45, at 11:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27, 19 45, to June 29, 19 1945

and that I last saw him alive on June 29, 19 45

Immediate cause of death Perforated duodenal ulcer, | DURATION

Due to Delayed, operation | 30 hours

Due to Diffuse peritonitis | duration

Other conditions Large perforation, large accumulation in abdomen
(Include pregnancy within 3 months of death)

Major findings of operations Diff peritonitis

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE A H Hawkins M. D. or other

Address ... Date signed 6/30/45

Enfield

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-c)

CERTIFICATE OF DEATH

(5606

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

547 Green St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 547 Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Ella M. Beall

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Joseph E. Beall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 20, 1879

8. AGE: Years	Months	Days	If less than one day
65	6	15	..... hrs. ..... min.

9. Birthplace Mt. Savage, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER

12. Name Samuel F. Pipey

13. Birthplace Sharpsburg Md.

MOTHER

14. Maiden name Caroline Sills

15. Birthplace Cumberland, Md

16. Informant Trustee Beall

Address 547 Green St

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8, 1945 (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Mt. Savage, Md.

18. Funeral director John G. Hofer

Address Cumberland, Md.

19. June 7, 1945 (Date rec'd by registrar) Winter R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1945, at 8:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5, 1945, to June 5, 1945

and that I last saw her alive on June 5, 1945

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. C. Beall M. D. or other

Address Cumberland Date signed 6/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1140)

05607

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cresaptown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Charles Russell Beveridge

3.(b) Social Security Number: 214-07-1938

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Beatrice Williams

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): June 7, 1891

8. AGE:	Years	Months	Days	If less than one day
	54	0	10	...hrs. ...min.

9. Birthplace: Lonaconing Allegany, Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Building trades

FATHER — 12. Name: Charles Beveridge

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Mary Savage

15. Birthplace: Unknown

16. Informant: Richard F. Beveridge

Address: Cresaptown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19, 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: John F. Hofer

Address: Cumberland, Md.

19. June 19 1945 (Date rec'd by registrar) Winter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17, 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1945, to June 17 1945 and that I last saw h... alive on June 16 1945

Immediate cause of death	DURATION
pneumonitis	7 days
Due to: sinusitis	Many years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: L. Winter M.D. M. D. or other

Address: Lonaconing, Md. Date signed 6-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

05608

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 wks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

Street No. 430 Spruce (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Sophia Jane Brode

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Conrod Brode

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 16-1867

8. AGE: Years	Months	Days	If less than one day
77	11	29	..... hrs. ..... min.

9. Birthplace: Australia (Town, county, and state)

10. Usual occupation: house wife

11. Industry or business

FATHER 12. Name: Mason

FATHER 13. Birthplace: Australia

MOTHER 14. Maiden name: unknown

MOTHER 15. Birthplace: Australia

16. Informant: Geo. Brode

Address: Westernport

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17-1945 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: J. J. Dutey

Address: Frostburg, Md.

19. June 15 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1945, at 1.25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 14 1945, to June 15 1945 and that I last saw h.e.r alive on June 14 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to: Arteriosclerosis	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: P E Berry M. D.

M. D. or other

Address: Piedmont W. Va. Date signed: 6/15/45

Outside of City Limits

CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (850)

CERTIFICATE OF DEATH

056[illegible]9

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 Years

Hospital, institution, or street address where death occurred: Bedford Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Bedford Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Urias Milton Brown

3. (b) Social Security Number: 705-10-7776

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Brown

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): June 26 1878

8. AGE: Years	Months	Days	If less than one day
67	0	1	...hrs. ...min.

9. Birthplace: Meyersdale, Somerset Co, Penna (Town, county, and state)

10. Usual occupation: Flagman

11. Industry or business: Western Maryland Railroad

FATHER

12. Name: Michael Brown

13. Birthplace: Meyersdale, Pa.

MOTHER

14. Maiden name: Sarah Marteeney

15. Birthplace: Michigan

16. Informant: Mrs. U. M. Brown

Address: Bedford Road, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/30/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kicht

Address: Cumberland, Md.

19. June 30, 1945 (Date rec'd by registrar) Winter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1945 at 7-45 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/23 1945 to 6/25 1945 and that I last saw him alive on 6/25 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	6 days
Due to arterial hypertension	
Due to	
Other conditions Chronic glomerulonephritis due to old hemorrhage years ago	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Briggs M. D. or other

Address: Corp. Md. Date signed 6/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BFD)

CERTIFICATE OF DEATH

15610

Reg. Dist. No. 1 7

1. PLACE OF DEATH:

County Allegany

City or town Piccardy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: R F D # 1 Paw Paw W. Va

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Piccardy

(If outside city or town limits, write RURAL and give nearest town)

Street No. R F D # 1 Paw Paw W. Va

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Verda Leona Burch

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~ Samuel C. Burch.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 7 1900

8. AGE: Years	Months	Days	If less than one day
44	8	8	..... hrs. ..... min.

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home.

FATHER 12. Name Wm Morgan

13. Birthplace Md.

MOTHER 14. Maiden name Martha Barnes

15. Birthplace Md.

16. Informant Wm. Morgan

Address Piccardy Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19 45 (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland

19. June 19 1945 (Date rec'd by registrar) Mrs C A Shanholtz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 1.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 1945, to June 15 1945

and that I last saw h alive on June 15 1945

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R M Teachers M. D. or other

Address 49 Grievue St Date signed 6-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr Smithers
for
Stein

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-E)

CERTIFICATE OF DEATH

11-5611

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 17 hrs 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 76 Bowery
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Baby Boy Carder (1st twin)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 6/2/45

8. AGE: Years	Months	Days	If less than one day
			17 hrs. 20 min.

9. Birthplace: Frostburg Md (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Elmer James Carder
13. Birthplace: Frostburg Md
MOTHER 14. Maiden name: Mary Agnes Lathrum
15. Birthplace: Lonaconing Md
16. Informant: Mrs Carder
Address: Frostburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-4-1945 (month) (day) (year)
Cemetery or crematory: Old Caney Cemetery
Location: Lonaconing, Md
18. Funeral director: Jacob Wagner
Address: Frostburg, Md.
19. 6-4 1945 Wm. Harvey N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1945, at 3:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1945 to June 3 1945 and that I last saw him alive on June 3 1945

Immediate cause of death	DURATION
Premature Labor	
Due to: Placenta Previa	
Due to: Twinning & mother	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hilda Jones Mahoney M.D.
M. D. or other
Address: Frostburg Md Date signed: 6/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-C)

CERTIFICATE OF DEATH

T 05612

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 6 hrs 18 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 76 Bowery St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Baby Boy Carder (2nd twin)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/45

8. AGE: Years	Months	Days	If less than one day
			6 hrs. 18 min.

9. Birthplace Frostburg Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Elmer James Carder
FATHER 13. Birthplace Frostburg Md

MOTHER 14. Maiden name Mary Agnes Featherman
MOTHER 15. Birthplace Lonaconing Md

16. Informant Mrs Elmer Carder
Address Frostburg Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 6-4-1945 (month) (day) (year)
Cemetery or crematory Old County Cemetery
Location Lonaconing, Md.
18. Funeral director Jacob Wagner
Address Frostburg, Md.

19. 6-4 1945 Mrs. Nancy A. Rae
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1945, at 4 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1945 to June 3 1945 and that I last saw h[illegible] alive on June 3 1945

Immediate cause of death	DURATION
Prematurity	
Due to Twisting + placenta previa	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Hilda Jane Walters M.D.
M. D. or other
Address Frostburg Md Date signed 6/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-a)

CERTIFICATE OF DEATH

05613

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Midlothian

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midlothian

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Keirs Chapman

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Chapman

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): January 18, 1870

8. AGE:

Years	Months	Days	If less than one day
75	5	20	...hrs. ...min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER — 12. Name: John Keirs

13. Birthplace: Scotland

MOTHER — 14. Maiden name: Janet Morton

15. Birthplace: Scotland

16. Informant: Walker Chapman

Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 10, 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md

18. Funeral director: J. J. Dent

Address: Frostburg Md

19. 6-10 (Date rec'd by registrar) 1945 Mrs Nancy N Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7 1945, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942 1945, to June 7 1945

and that I last saw her alive on June 13 1945

Immediate cause of death	DURATION
Pernicious Anaemia	several years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. M. McLane Jr. M.D. M. D. or other

Address: Frostburg Md Date signed: June 9 1945

~~DR. WILSON~~ &
DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

5614

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: FLINTSTONE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MRS. HESTER CHENEY

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife: MILLARD CHENEY
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): OCTOBER 20, 1861

8. AGE: Years	Months	Days	If less than one day
83	7	18	..... hrs. ..... min.

9. Birthplace: MARYLAND
(Town, county, and state)

10. Usual occupation: HOUSE WORK

11. Industry or business

FATHER
12. Name: ASHFORD WILLISON
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: ~~HARRIET~~ NEWELL
15. Birthplace: ~~MARYLAND~~ Connecticut

16. Informant: H.K.CHENEY
Address: FLINTSTONE, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10 1945 (month) (day) (year)
Cemetery or crematory: Fellerest Cem
Location: Cumberland, Md.

18. Funeral director: John J. Yates
Address: Cumberland, Md.

19. June 9, 45 Winter R. Trautz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: JUNE 8, 1945 at 3;00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1945 to June 8 1945 and that I last saw h.. alive on June 8 1945

	DURATION
Immediate cause of death: 2 minutes	
Due to: Old Age	
Due to: Incarcerated Ventral Hernia, Refused Operation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland, Md. Date signed: 6-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Louis Bruce

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH

F 05615

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Emanuel Clayton

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carrie Barkley Clayton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 22, 1872

8. AGE: Years	Months	Days	If less than one day
72	8	19	..... hrs. ..... min.

9. Birthplace: Pennelton Co. W. Va.
(Town, county, and state)

10. Usual occupation: Retired Engineer

11. Industry or business: Dry Fork R.R. Co.

FATHER
12. Name: Samuel Clayton
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mr. Theodore Clayton

Address: Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12, 1945 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cem.

Location: Bedford Road

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. June 11 19 45 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 19 45, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 19 42, to June 10 19 45 and that I last saw h.. alive on June 8 19 45

Immediate cause of death	DURATION
Congestive heart failure	1 year
Due to chronic myocarditis	4 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L Bruce M D
M. D. or other

Address: Lonaconing Md Date signed 6-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

65816

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15-

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 yrs.

Hospital, Institution, or street address where death occurred: 632 Hilltop Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 632 Hilltop Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry Jacob Coughenour

3.(b) Social Security Number 705-07-9713

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Genevieve Boward 6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) June 1, 1894

8. AGE:	Years	Months	Days	If less than one day
	51	0	20	...hrs. ...min.

9. Birthplace Connellsville, Fayette Co., Pa.
(Town, county, and state)

10. Usual occupation Brakesman

11. Industry or business B. & O.

FATHER 12. Name Alexander Coughenour

13. Birthplace Pa.

MOTHER 14. Maiden name Bessie M. Rice

15. Birthplace Pa.

16. Informant John C. Coughenour

Address 105 Robbins St - Connellsville Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25 1945 (month) (day) (year)

Cemetery or crematory St. Lukes Lutheran Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland.

19. June 25 19 45 Winter R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1945 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 45 to June 21 1945 and that I last saw him alive on June 21 1945

Immediate cause of death	DURATION
Chronic Myocarditis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

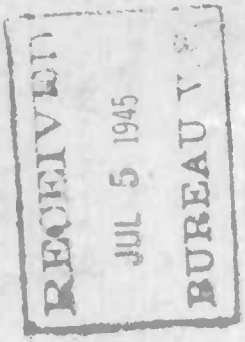
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Jones M.D.
M. D. or other

Address Cumberland, Md. Date signed 6-25-45

Please call
65
when this is signed.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05617

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 680 GREEN ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: BLANCHE GREEGAN

3. (b) Social Security Number: 214-05-4183

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: PATRICK J. GREEGAN
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): JAN. 28 1897

8. AGE: Years	Months	Days	If less than one day
48	4	21	...hrs. ...min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: Housewife - Stenographer
11. Industry or business: Home
FATHER 12. Name: John A. Bradley
13. Birthplace: Maryland
MOTHER 14. Maiden name: BERTHA McCALL
15. Birthplace: MD.
16. Informant: Patrick J. Greegan
Address: Cumberland Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 21 1945 (month) (day) (year)
Cemetery or crematory: St. Patricks Cem.
Location: Cumberland, Md.
18. Funeral director: Louis Stein Inc
Address: Cumberland, Md.
19. June 20 1945 Winter R. Brant, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: JUNE 19, 1945, at 4:53 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1945 to June 19 1945 and that I last saw h.. alive on June 19 1945

Immediate cause of death	DURATION
Encephalitis	2 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.: none
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide... Date of...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 6-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

T 05615

Reg. Diat. No.

1. PLACE OF DEATH:
County: Allegany
City or town: One Half Mile East McKenzie, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mary l and County: Garrett
City or town: Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Wesley Franklin Davis

3.(b) Social Security Number: 218-01-6937

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1906

8. AGE: Years	Months	Days	If less than one day
38	8	15	hrs. min.

9. Birthplace: Kitzmiller, Garrett Co., Md.
(Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mines

FATHER
12. Name: Benjamin Franklin Davis
13. Birthplace: Elk Garden, W.Va.

MOTHER
14. Maiden name: Sicey May Cornell
15. Birthplace: Hartmansville, Mineral Co., W.Va.

16. Informant: Mrs. Maxine Dixon,
Address: Kitzmiller, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12, 1945 (month) (day) (year)
Cemetery or crematory: I.O.O.F. Cemetery
Location: Elk Gard en, W.Va.

18. Funeral director: Otha F. Sharpless
Address: Blaine, W.Va.

19. 6/11 (Date rec'd by registrar) 19 45 M.J. Vanmeter (25) Registrar

MEDICAL CERTIFICATION about P.

20. DATE OF DEATH: June 9th., 19 45, at 10.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Decapitation and multiple amputations — DURATION: killed instantly.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 6-9-45
Where did injury occur? Near Seymour, Allegany, Maryland.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Railroad
Means of injury: mangled by wheels Injured at work? no

23. SIGNATURE: Bruce H. Brown, M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 6-10-45

Deputy Medical Examiner, Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05619

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany County

City or town 2 miles east of Cumberland on Rt. 40

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Washington

City or town Hancock

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war None ✓

3.(a) FULL NAME Howard H. Dick

3.(b) Social Security Number 705-10-4817

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Emma R. Weisenmiller

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1881

8. AGE:	Years	Months	Days	If less than one day
	63	9	13	..... hrs. ..... min.

9. Birthplace Jones Springs, W. Va. (Town, county, and state)

10. Usual occupation Telegraph Operator

11. Industry or business W. M. Railroad

FATHER 12. Name Robert Dick

13. Birthplace Fairfax, Va.

MOTHER 14. Maiden name Angeline Schimpf

15. Birthplace Jones Springs, W. Va.

16. Informant Mrs. Thomas O. Jones

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20, 1945 (month) (day) (year)

Cemetery or crematory Episcopal Cemetery

Location Hancock, Md.

18. Funeral director John J. Hoffman

Address Cumberland, Md.

19. June 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945, at 12:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death Fracture third Cervical Vertebra — DURATION: killed instantly.

Due to

Due to

Other conditions Comp. frac. left femur lower third. Multiple lac. and contustions on face and body.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-17-45

Where did injury occur? Belle Grove, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway #40

Means of injury auto accident Injured at work? no

23. SIGNATURE Bruce H. Brown, M.D. M. D. or other

Address Cumberland, Maryland Date signed 6-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

05620

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 20 Browning St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Alleg.

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 Browning St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John J. Dougherty

3. (b) Social Security Number: 712-14-1551

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rose Fleckenstein

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. - 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	-	-		

9. Birthplace: Piedmont W Va.
(Town, county, and state)

10. Usual occupation: Train Dispatcher

11. Industry or business: B.R.C.

FATHER — 12. Name: Thomas Dougherty

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Mary Purcell

15. Birthplace: Ireland

16. Informant: Mrs Rose Dougherty

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23 1945 (month) (day) (year)

Cemetery or crematory: St Pat's Cem

Location: Cumberland Md

18. Funeral director: Loucks Sons Inc.

Address: Cumberland Md.

19. June 22, 1945 (Date rec'd by registrar) Winter R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 1945, at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated: (a) I attended deceased from June 17 1945 to June 20 1945

and that I last saw h... alive on June 20 1945

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to: Arterio Sclerosis + diabetes — Duration: 3 yrs

Due to: — Duration:

Other conditions: — Duration:

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: M E Bowers M.D.
M. D. or other

Address: 133 Va. Ave Date signed: 6/21/45

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

05621

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred: Narrows Park.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Narrows Park.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lucinda Jane Earsom

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife James E. Earsom

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 31 1857

8. AGE: Years 87 | Months 7 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace Stapleton Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Jacob Wise

13. Birthplace Pa.

MOTHER 14. Maiden name Elizabeth Poster

15. Birthplace Pa.

16. Informant Herbert Earsom

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24 '45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. June 25, 1945 (Date rec'd by registrar) Winter R. Franz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1945, at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1945, to June 21 1945, and that I last saw h.. alive on June 20 1945.

Immediate cause of death	DURATION
complete heart failure	
Due to	
Due to	
Other conditions Fractured Hip:	Since May 10-1945
Due to: Accidental fall. Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Fractured Hip by fall Date of 5-10-45

Where did injury occur? At home Long Meadow
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Long Meadow

Means of injury ..... Injured at work?

23. SIGNATURE L. Brinn M.D.
M. D. or other

Address Long Meadow Date signed 6-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BFC)

CERTIFICATE OF DEATH

T 05622

Reg. Dist. No. 9

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

(1) MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Allegany

City or town Eckhart Mines, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:
Eckhart Mines, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart Mines, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Pearl Marnella Eckhart

3.(b) Social Security Number 236-36-1299

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John Thos. Eckhart

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Aug. 5th. 1900

8. AGE: Years 44 | Months 9 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace Garrett Co. Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Wm. P. Snyder

FATHER 13. Birthplace Garrett Co. Md.

MOTHER 14. Maiden name Viola J. Fazenbaker

MOTHER 15. Birthplace Garrett Co. Md.

16. Informant Mr. Thomas Eckhart

Address Eckhart Mines Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-3-1945 (month) (day) (year)

Cemetery or crematory Eckhart Cemetery

Location Eckhart, Md.

18. Funeral director Jacob Kaler

Address Frostburg, Md.

19. 6-2-1945 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6.1.1945 at a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12.11.1944 to 6.1.1945 and that I last saw her alive on 5.12.1945

Immediate cause of death	DURATION
(a) Chronic Myocardial Degeneration	
Due to (b) Chronic Nephritis	
Due to (c) Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 6.2.45

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05623

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town OAKLAND BOX 102
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war V

3.(a) FULL NAME ~~MR. WILLIAM EVERETT~~ Charles W. Everts

3.(b) Social Security Number 236-01-9700

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife THERESA ~~CONAWAY~~ Conaway Everts 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 28, 1877

8. AGE: Years	Months	Days	If less than one day
~~68~~ 67	5	9	..... hrs. ..... min.

9. Birthplace ~~MARYLAND~~ Garrett Co., Maryland (Town, county, and state)

10. Usual occupation TEAMSTER

11. Industry or business PRITT'S LUMBER CO.

FATHER 12. Name J. D. Everts
13. Birthplace Pennsylvania

MOTHER 14. Maiden name Margaret A. Knepp
15. Birthplace Maryland

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8, 1945 (month) (day) (year)

Cemetery or crematory Red House Cem
Location Red House, Md.

18. Funeral director Emroy Bolden
Address Oakland Md

19. June 6 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 6 1945 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-4- 1945, to 6-6- 1945 and that I last saw him alive on 6-5-45 1945

Immediate cause of death Arteriosclerosis & Myocardial degeneration ? — DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard L. Tolson M.D. M. D. or other

Address Cumberland Md Date signed 6-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Rb-a)

05624

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNA County BEDFORD
City or town HYNDMAN
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. MINERVA J, FISHER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife THOMAS E. FISHER
6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) August 15, 1865

8. AGE: Years 79 | Months 9 | Days 18 | If less than one day hrs. min.

9. Birthplace PENNA. Gravel Pit (Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name Frederick J. Stutzy
13. Birthplace Pennsylvania

MOTHER
14. Maiden name MARY JANE WERTZ
15. Birthplace Pennsylvania

16. Informant MRS. JULIA FISHER
Address HYNDMAN

17. (Burial, cremation, or removal. Which?) Burial Date thereof June 5, 1945 (month) (day) (year)

Cemetery or crematory Lybarger Cem
Location Buffalo Mills, Pa.

18. Funeral director Harvey A. Zeigler
Address Hyndman Penna

19. June 5 1945 (Date rec'd by registrar) Winter P. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 3, 1945 at 2;25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 45 to June 3 19 45 and that I last saw h 2 R alive on June 3 19 45

Immediate cause of death	DURATION
Thrombosis	30 yrs
Myocarditis	
Due to	
Due to Accidental fall. Cuts	
Other conditions	
Trochanteric fracture	

(Include pregnancy within 3 months of death)

Major findings of operation Left femur
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of
Where did injury occur? Hyndman (City or town) Pa. (County) (State)
Injured at home, farm, industry, public place (where?) At Home
Means of injury Accidental fall. Injured at work?

23. SIGNATURE John A Topper M.D.
M. D. or other
Address Hyndman Pa. Date signed June 4, 194

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Koontz

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-C)

CERTIFICATE OF DEATH

05625

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 yrs.

Hospital, Institution, or street address where death occurred: 445 Balto Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 445 Balto Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Nellie Alberta Flake

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Argyle Flake

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Aug 12, 1879

8. AGE:

Years	Months	Days	If less than one day
65	10	0	...hrs. ...min.

9. Birthplace: Near Cumberland, Allegany Co. Md

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home.

FATHER

12. Name: J. A. B. Bowden

13. Birthplace: Near Cumberland, Md.

MOTHER

14. Maiden name: Blanche Christie

15. Birthplace: Near Cumberland, Md.

16. Informant: Mr Argyle Flake

Address: 445 Balto Ave Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14, 1945 (month) (day) (year)

Cemetery or crematory: Pleasant Grove Methodist

Location: Cumberland Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. June 14, 1945 (Date rec'd by registrar) Winter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 1945, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1945, to June 12 1945

and that I last saw h[er] alive on June 11 1945

Immediate cause of death	DURATION
Organic Heart Disease	7 Yrs.
Due to Chronic Nephritis	11 Yrs
Due to Diabetes	0 Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos. A. Evans M. D. or other

Address: Cumberland Md Date signed 6/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

[redacted] GRACE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

05626

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County GRANT
City or town GORMANIA W. VA.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME ELIZABETH FOWLER

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife L. D. FOWLER
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) July 3 1865

8. AGE: Years	Months	Days	If less than one day
79	11	14	....hrs. ....min.

9. Birthplace Frostburg, Maryland.
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business

FATHER
12. Name JOHN R RAESE
13. Birthplace GERMANY

MOTHER
14. Maiden name ELIZABETH KNISE
15. Birthplace GERMANY

16. Informant MRS. LAURA HARVEY
Address GORMANIA, W. VA.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JUNE 19, 1945 (month) (day) (year)
Cemetery or crematory Davis Cemetery
Location Davis, W.VA.
18. Funeral director Emery Bolden
Address Oakland Md

19. June 18, 1945 (Date rec'd by registrar) Winter R. Grant, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 17, 1945 19.... at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1945 to June 17 1945 and that I last saw h.. alive on June 16 1945

Immediate cause of death	DURATION
Pneumonia Lobar	
Cardiac collapse	
Due to Fractured left humerus	
Due to Heart-Failure	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. G. Grace M. D. or other
Address Cumberland Date signed June 17-45

VS A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

05627

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Huffman Mines — Mt. Savage (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Huffman Mines (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Julia Frank

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30 — 1872

8. AGE:

Years	Months	Days	If less than one day
72	11	15	..... hrs. ..... min.

9. Birthplace Huffman Mines, Md. (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name Andrew Frank
13. Birthplace Germany

MOTHER
14. Maiden name Sophia Metzger
15. Birthplace Germany

16. Informant Edgar Frank
Address Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15 1945 (month) (day) (year)

Cemetery or ~~cemetery~~ German Lutheran

Location Frostburg, Md.

18. Funeral director J. J. Beachy
Address Frostburg

19. 6-14 1945 Mrs. Hawley A. Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 10:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 13 1943, to June 13 1945 and that I last saw h~~e~~er alive on June 2 1945

Immediate cause of death Cerebral hemorrhage — DURATION: Sudden onset

Due to

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. C. Lane M.D. M. D. or other

Address Frostburg Md. Date signed June 13 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

05628

★

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS (I)

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 mo 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED.

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 518 Dreyer Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Adolph Ferdinand Fraund.

3.(b) Social Security Number 217-10-4860

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Rose Rubino

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 7 1893

8. AGE: Years	Months	Days	If less than one day
51	9	23	..... hrs. ..... min.

9. Birthplace New York City N.Y. (Town, county, and state)

10. Usual occupation Chemist Corp

11. Industry or business artificial silk.

FATHER 12. Name Moritz Fraund.

13. Birthplace Germany

MOTHER 14. Maiden name Caroline

15. Birthplace Germany.

16. Informant Mrs Rose Fraund

Address 109 E 37th St. Brooklyn N.Y.

17. Burial & Removal (Burial, cremation, or removal. Which?) Date thereof June 30 '45 (month) (day) (year)

Cemetery or crematory New York Cem

Location New York City

18. Funeral director Louis Stein Inc

Address Cumberland

19. June 30 1945 (Date rec'd by registrar) Walter R. Frauk, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 30 1945, at 12:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1945, to June 30 1945

and that I last saw h.im alive on June 30 1945

Immediate cause of death Cerebral-

Arteriosclerosis

with Hypertension

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. B. Leukeuos M.D. M. D. or other

Address 4 G Greene St Date signed 6-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-C)

CERTIFICATE OF DEATH

05629

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
235 Maple St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 235 Maple St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Ellen Gaslitz

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: Joseph Gaslitz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 13 1858

8. AGE: Years: 87 | Months: 4 | Days: 13 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Salisbury, Pa
(Town, county, and state)

10. Usual occupation: invalid

11. Industry or business

FATHER — 12. Name: Ferdinand Berg

13. Birthplace: Germany

MOTHER — 14. Maiden name: Phoebe Tedrow

15. Birthplace: Pa.

16. Informant: Mrs. Wm. Baker

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28 1945 (month) (day) (year)

Cemetery or crematory: Lafayette

Location: Salisbury, Pa

18. Funeral director: J. P. Dieh

Address: Frostburg, Md.

19. 6-27 1945 (Date rec'd by registrar) Mrs. Mandy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1945, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1944 to June 26 1945 and that I last saw her alive on June 25 1945

Immediate cause of death	DURATION
Carcinoma of Stomach	3 yrs.
Due to Senility	
Due to Arterio sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: H. C. Dieh, M.D.
M. D. or other

Address: Frostburg, Md. Date signed 6/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-E)

CERTIFICATE OF DEATH

05630 ★ Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING — VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 89 Broadway
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alpha Garrett

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 10, 1878

8. AGE: Years: 67 | Months: 2 | Days: 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Eckhart Allegany Cty Md (Town, county, and state)

10. Usual occupation: teacher

11. Industry or business: Public school

FATHER — 12. Name: Joseph Garrett
FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Nancy E. Anderson
MOTHER — 15. Birthplace: Maryland

16. Informant: Raymond J. Garrett
Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22 1945 (month) (day) (year)
Cemetery or crematory: Eckhart Cemetery
Location: Eckhart Md.

18. Funeral director: J. J. Deirst
Address: Frostburg Md.

19. 6-22 1945 Mrs. Nancy N. Ross
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 1945 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1945, to June 20 1945 and that I last saw h[illegible] alive on June 20 1945

Immediate cause of death	DURATION
Acute Cardiac dilatation	6 Days
Due to: Hypertension	Several years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D.
M. D. or other
Address: Frostburg Md. Date signed 6-21-45


RECEIVED
JUN 25 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127-E)

CERTIFICATE OF DEATH

05631

★ Reg. Diat. No. 8

1. PLACE OF DEATH:
County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: Detained
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Detained
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Mrs. Jennie McMillan Green

3.(b) Social Security Number —

4. Sex	5. Color or Race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Franklin P. Green
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1864

8. AGE: Years 80 | Months 8 | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace Franklin, Allegany Co, Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

FATHER
12. Name Hugh McMillan
13. Birthplace Scotland

MOTHER
14. Maiden name Mary Smith
15. Birthplace Scotland

16. Informant Mrs. Bessie Green Andrews
Address Charleroi, Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13 1945 (month) (day) (year)
Cemetery or crematory Laurel Hill Cemetery
Location Luzon Md.

18. Funeral director M. Eichhorn
Address Lonaconing, Md.

19. June 12 1945 W. E. Thomas
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11th 1945, at 8 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945, to June 11 1945
and that I last saw h... alive on June 10 1945

Immediate cause of death	DURATION
Bronch. Pneumonia	1 day.
obstruction of gall bladder	10 days.
Due to not due to cancer. Q.W.S.P.	
Due to	
Other conditions Bronchitis.	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Dr. E. Thomas M. D. or other
Address Lonaconing Date signed 6/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. ~~Wilson~~ Jacobson

05632

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Mr. Orland Green

3. (b) Social Security Number
Unable to locate

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marguerite Monahan
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): June 9, 1894

8. AGE: Years	Months	Days	If less than one day
~~52~~ 51	11	28	hrs. min.

9. Birthplace: Maryland, Bloomington
(Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Consolidation Coal Co.

FATHER
12. Name: Walter Green
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mahala Fazenbaker
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 11, 1945 (month) (day) (year)
Cemetery or crematory: St Michael's Cem
Location: Frostburg, Md.
18. Funeral director: M Eschbach
Address: Lonaconing

June 9, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7, 1945, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5, 1945, to June 7, 1945
and that I last saw him alive on June 7, 1945

Immediate cause of death	DURATION
(a) Uremia	2
Due to: Hypertensive cardio-vascular-renal disease. Duration: Unknown	
Due to:	
Other conditions: Secondary Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Samuel D. Jacobson M.D.
Address: 15 S. Liberty St. Date signed: 6/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-F)

05633

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, Institution, or street address where death occurred:

229 Oak St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 229 Oak St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bessie Marian Gross

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Perry Gross

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1891

8. AGE:

Years	Months	Days	If less than one day
53	5	25	..... hrs. ..... min.

9. Birthplace Kifer Alley Co., Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER

12. Name Andrew Robertson

13. Birthplace Md.

MOTHER

14. Maiden name Martha Roby

15. Birthplace Md.

18. Informant Mrs Vivian De Vore

Address 1119 Battery Ave - Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10 1945 (month) (day) (year)

Cemetery or crematory Mt Herman Cemetery

Location Near Cumberland

18. Funeral director John J Hafer

Address Cumberland Md

19. June 10 1945 Winter R. Hauty M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1945 at 9:36 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1945, to June 7 1945

and that I last saw h-- alive on June 7 1945

Immediate cause of death	DURATION
Carcinoma of liver.	
Duration - one year.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J Bailey Hunter M.D. M. D. or other

Address Cumberland Md Date signed 6/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

05634

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
309 Cecelia St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 309 Cecelia St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Etta Gross

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Charles Gross

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 5, 1861

8. AGE: Years	Months	Days	If less than one day
84	1	29	..... hrs. ..... min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business home

FATHER
12. Name James Grant
13. Birthplace West Virginia

MOTHER
14. Maiden name Elizabeth Weaver
15. Birthplace West Virginia

16. Informant Oliver W. Gross

Address RFD 4 Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6, 1945 (month) (day) (year)

Cemetery or crematory Ivewells

Location West Virginia

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. June 6 19 45 Winter R. Krantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 19 45, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 19 45, to June 4, 19 45, and that I last saw h[illegible] alive on May 20, 19 45.

	DURATION
Immediate cause of death Arteriosclerosis	10 yrs.
Due to Arteriosclerotic	5 yrs.
Due to Pneumonia	4 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alvey R. Furrow M. D. or other

Address Cumberland Date signed June 4, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

05635

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: McCoole
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: McCoole
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 Queen St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Nicholas Strother Haggerty

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Etta Frances Barb

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 30, 1867

8. AGE: Years	Months	Days	If less than one day
78	2	21	..... hrs. ..... min.

9. Birthplace: Hampshire Co., W.Va.
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: George W. Haggerty
13. Birthplace —

MOTHER
14. Maiden name: Elizabeth Jane Hershey
15. Birthplace: Ohio.

16. Informant: George G. Liller

Address: 2 Queen St. McCoole, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-23-45 (month) (day) (year)

Cemetery or crematory: Old Pine Church Cemetery

Location: near Purgittsville, W.Va.

18. Funeral director: N.L. Rogers Funeral Directors

Address: Keyser, W.Va.

19. June 26 1945 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21, 1945, at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to June 21, 1945 and that I last saw him alive on June 21 1945

Immediate cause of death	DURATION
Coronary artery Occlusion	
Due to Arteriosclerosis	
Chronic Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Norman Reece, M.D.
M. D. or other

Address: Westernport, Md Date signed 6-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

05636

Reg. Dist. No. 4

VS A15 (1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 93 yrs.
Hospital, institution or street address where death occurred:
815 Shriver Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 815 Shriver Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ernest Hartman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Caroline Hensey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 31 1852

8. AGE: Years	Months	Days	If less than one day
93	2	1	..... hrs. ..... min.

9. Birthplace Cumberland Md. (Town, county, and state)
10. Usual occupation Carpenter (Retired)
11. Industry or business B. & O. R.R.
FATHER 12. Name John Hartman
FATHER 13. Birthplace Germany
MOTHER 14. Maiden name Barbara Snyder
MOTHER 15. Birthplace Germany
16. Informant Wm. Hartman
Address Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-4-45 (month) (day) (year)
Cemetery or crematory St. Lukes Cem.
Location Cumberland Md
18. Funeral director Louis Stein Inc.
Address Cumberland.
19. June 4 1945 Walter L. Frantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-1-1945 at 10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-12-1944 to 6-1-1945
and that I last saw him alive on 5-28-1945

	DURATION
Immediate cause of death Bronchopneumonia	5 days
Due to Generalized Arteriosclerosis	
Due to Infirmities of Age	
Other conditions Fractured femur	
9-12-44 Accidental fall. C.W.S.R.	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Accident. Date of 7-12-1944.
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) At Home.
Means of injury Accidental fall. Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed 6-2-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05637

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86 yrs.

Hospital, Institution, or street address where death occurred: 423 Columbia St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 423 Columbia St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth M.Heier

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: John G.Heier

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 7th.,1859

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
86	2	21		

9. Birthplace: Cumberland, Maryland.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER — 12. Name: Conrad Betzold

13. Birthplace: Germany

MOTHER — 14. Maiden name: Margaret Hoffman

15. Birthplace: Germany

16. Informant: Mrs. Lawrence Crabtree

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June (month) 30th (day) 45 (year)

Cemetery or crematory: St. Lukes

Location: Cumberland, Maryland.

18. Funeral director: Louis Stein, Inc.,

Address: Cumberland, Maryland.

19. June 30 19 45 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28th., 19 45, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chronic Myocarditis	4 yrs.
Due to	
Due to	
Other conditions: Arterio-sclerosis	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: no operation

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Pierce H. Dorsey, M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 6-29-45

Outside City Limits

(M)

MARGIN RESERVED FOR BINDING

(1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

T 05638 4

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Narrows Park,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Narrows Park

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John R. Hershberger

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Eva Wigfield Hershberger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 26, 1866

8. AGE: Years	Months	Days	If less than one day
78	7	7	..... hrs. ..... min.

9. Birthplace: Cresaptown, Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Garage Work

FATHER 12. Name: Elijah Hershberger

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Minerva Shook

MOTHER 15. Birthplace: Unknown

16. Informant: Mr. Donald Chenoweth

Address: Narrows Park, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 5, 1945 (month) (day) (year)

Cemetery or crematory: HillCrest Cemetery

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. June 5, 1945 (Date rec'd by registrar) Walter R. Hauck, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2, 1945, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944, to June 2 1945 and that I last saw h.. alive on May 31 1945

Immediate cause of death: Acute Dilatation of Heart — DURATION: 1 hour

Due to: Hypertension Chronic Heart Disease and Diabetes — DURATION: 5 years and years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: T. Allen G. Hammond M. D. or other

Address: Cumberland Md. Date signed: June 4 45

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05639

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital.
How long in hospital or institution? 15 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEG.
City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 801 N. Fetterman Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME BESSIE HOGAN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	WIDOWED

6.(b) Name of husband or wife RICHARD HOGAN
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dont know

8. AGE: Years	Months	Days	If less than one day
80			hrs. min.

9. Birthplace Cumberland Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name GREEN, WILLIAM
13. Birthplace Pa.

MOTHER
14. Maiden name >, SARA
15. Birthplace Unknown

16. Informant August Hogan
Address Canton, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20 45 (month) (day) (year)
Cemetery or crematory St Patrick Cem.
Location Cumberland, Md.

18. Funeral director Louis Stein Inc.
Address Cumberland, Md.

19. June 19 1945 Winter R. Frantz, M. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 16, 1945, at 6:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1- 1945 to 6.16.1945 and that I last saw h.. alive on 6.16.1945

Immediate cause of death	DURATION
Broncho Pneumonia	7
Infirmities of age	lap.
Due to	
Due to	
Other conditions Fell & broke left femur	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland, Md. Date signed June 19

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 26 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

05640

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 70 Grand Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 Grand Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME (Virginia Bell) Jennie Bell Hohing

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John J Hohing

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 27, 1869

8. AGE:	Years	Months	Days	If less than one day
	75	9	7	..... hrs. ..... min.

9. Birthplace: West. Va.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: own Home

FATHER 12. Name: — Butts

FATHER 13. Birthplace: — Unknown

MOTHER 14. Maiden name: — Conn.

MOTHER 15. Birthplace: Unknown

16. Informant: Mrs Ed Eirich

Address: Cumberland md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8 45 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland md.

19. June 6 19 45 (Date rec'd by registrar) Winter L. Mauntz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 19 45, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 19 45, to June 4 19 45

and that I last saw h[illegible] alive on June 2 19 45

Immediate cause of death: Diabetes

	DURATION
Diabetes	several yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. V. Dening M.D. M. D. or other

Address: 125 Bedford St. Date signed 6/5/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

05641

CERTIFICATE OF DEATH

★ Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 months
Hospital, Institution or street address where death occurred:
Sylvan retreat
How long in hospital or institution? 13 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Ann Hughes

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Michael Hughes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 11, 1873

8. AGE: Years	Months	Days	If less than one day
72	1	12	..... hrs. ..... min.

9. Birthplace: Mt. Savage, Allegany, Md.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home

FATHER
12. Name: Jacob Porter
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary McGrogan
15. Birthplace: Scotland

16. Informant: Mrs. Hugh Donahue
Address: Frostburg Md.

17. Burial (Burial, cremation, or removal: Which?) Date thereof June 27-45 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg Md.

18. Funeral director: J. J. Birst
Address: Frostburg, Md.

19. June 26 1945 Martha A. Zant, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6. 24. 1945, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from May 9, 1944 to 6. 24. 1945 and that I last saw her alive on 6. 23. 1945

Immediate cause of death	DURATION
Gastro-enteritis	
Generalized Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.: none
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Williams M. D.
Address: Cumberland Date signed: 6-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Eliasen

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (105)

CERTIFICATE OF DEATH

15642

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day.
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Barrellsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Sandra James

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 28 1945

8. AGE: Years	Months	Days	If less than one day
3 mo.	3	14	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: Charles James
13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Lula ~~Comvicle~~ Conwich
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/13/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem
Location: Cumberland

18. Funeral director: Lowis Stein & Sons
Address: Cumberland, Md.

19. June 13, 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11, 1945, at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 10 1945 to June 11 1945 and that I last saw h... alive on June 11 1945

Immediate cause of death	DURATION
Upper Respiratory Infection	7 days.
Acute Laryngitis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H. H. Eliasen M.D. M. D. or other
Address: 126 Greene St. Cumberland Date signed 6/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (179-A)

CERTIFICATE OF DEATH

F 05643

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany.
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 yrs.
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany.
City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 117 Wilmard ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Flora Elizabeth Jenkins

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Fred W. Jenkins
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1912

8. AGE:	Years	Months	Days	If less than one day
	32	11	23	hrs. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business Own Home.
FATHER 12. Name Samuel Evans
13. Birthplace W. Va.
MOTHER 14. Maiden name Annie E. Foy
15. Birthplace W. Va.
16. Informant Fred W. Jenkins
Address Cumberland Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6, 1945 (month) (day) (year)
Cemetery or crematory Hillcrest. Cem.
Location Cumberland, Md.
18. Funeral director Louis Steen Inc.
Address Cumberland, Md.
19. June 6 19 45 Winter L. Frantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd., 1945, at about 11 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Accidental Barbiturate Poisoning.	Unknown
Due to	
Due to	
Other conditions (Ingestion large amount of alcohol, presumably)	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide accident Date of 6-3-45
Where did injury occur? Cumberland, Allegany, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury Acc. Poisoning Injured at work? no

23. SIGNATURE Pierce H. Brown, M.D.
M. D. or other
Address Cumberland, Maryland Date signed 6-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5th)

CERTIFICATE OF DEATH

05644

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 45 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County HAMPSHIRE
City or town ROMNEY
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR BEN F. KING

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife BERTHA SHILLINGBERG
6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) DEC. 4, 1894

8. AGE: Years	Months	Days	If less than one day
50	6	10	hrs. min.

9. Birthplace ROMNEY W. VA. (Town, county, and state)
10. Usual occupation DAIRYMAN
11. Industry or business Own dairy

FATHER
12. Name BENJAMIN F. KING
13. Birthplace W. VA.

MOTHER
14. Maiden name LYDIA PULTZ
15. Birthplace W. VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-16-45 (month) (day) (year)
Cemetery or crematory Indian Mound
Location Romney. W. VA.

18. Funeral director Thrush's
Address Romney. W. VA.

19. June 15, 1945 Winter R. Trantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 14, 1945, at 4:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-9- 1944 to 6-14- 1945 and that I last saw h.i.m alive on 6-13- 1945

Immediate cause of death	DURATION
Carcinoma of Bladder	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Tolson M.D.
M. D. or other
Address Cumberland Md Date signed 6-14-45

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
PLEASE WRITE PLAINLY, WITH UNFADING INK.
VS A15

WITHIN CORPORATE LIMITS

05645

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 435 Pine Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jonathan H. Lee

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Negro	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 21, 1945

8. AGE:	Years	Months	Days	If less than one day
	0	4	9	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany, Md
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Major T. Lee
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden name Elizabeth R. Mann
15. Birthplace Cumberland, Md.

16. Informant Major T. Lee

Address 435 Pine Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2, 1945 (month) (day) (year)

Cemetery or crematory Sts Peter & Paul Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. July 2, 19 45 (Date rec'd by registrar) Winter L. Trump M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945, at 7:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1945, to June 30 1945

and that I last saw h... alive on June 30 1945

Immediate cause of death ..... Cardiac failure — Collapse — DURATION: acute

Due to ..... Sepsis — DURATION: 5 da

Due to ..... Infection — DURATION: 5 da

Other conditions ..... DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE M. D. Queen M. D. or other

Address 133 Va. Ave Date signed 7/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-C)

05646

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, Institution, or street address where death occurred: Cottage Hosp. Mason Park
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mason Park, Rt 40
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Benjamin B. Lyon

3.(b) Social Security Number 215-16-4458

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Henrietta Rinsell
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 23 1863

8. AGE: Years	Months	Days	If less than one day
81	1	17	____ hrs. ____ min.

9. Birthplace Michigan
(Town, county, and state)
10. Usual occupation Accountant
11. Industry or business

FATHER
12. Name Gideon Lyon
13. Birthplace New York

MOTHER
14. Maiden name Louise Ward
15. Birthplace England

16. Informant Mrs O B Lyon
Address Rt 40 Mason Park
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 45 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director Louis Stein Inc.
Address Cumberland Md
19. June 12 1945 (Date rec'd by registrar) Walter R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1945, at 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1945, to June 10 1945
and that I last saw him alive on June 10 1945

	DURATION
Immediate cause of death Cardiac Dilatation	
Due to Acute Influenza	1 day
Due to Chronic Bronchitis	2 wks.
Other conditions	40 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. Allen J. Hammond M. D.
M. D. or other
Address 44 E. Main St. Date signed June 12 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52-T

CERTIFICATE OF DEATH

05647

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, Institution, or street address where death occurred: 30 Ridgeway Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 30 Ridgeway Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bertha A Malone

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Harry Malone

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 19 1885

8. AGE:	Years	Months	Days	If less than one day
	59	9	24	..... hrs. ..... min.

9. Birthplace Arlton Ind. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

FATHER 12. Name John Robeson

13. Birthplace Ind.

MOTHER 14. Maiden name Catherine Robeson

15. Birthplace Ind

16. Informant Mrs. H. M. Morrison

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16 45 (month) (day) (year)

Cemetery or crematory St. Patricks Cem.

Location Cumberland

18. Funeral director Louis Steinert Sons

Address Cumberland

19. June 15 1945 Walter R. Beatty, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death Carcinoma of bladder — DURATION 6 mos.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Pierre H. Robeson M.D.

M. D. or other

Address Cumberland, Maryland Date signed 6-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05648

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41 yrs.
Hospital, Institution, or street address where death occurred:
10 Mary St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 Mary St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Irvin Gilbert Mc Elfish

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Hinkle
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Jan 5, 1874

8. AGE:

Years	Months	Days	If less than one day
71	5	15	hrs. min.

9. Birthplace: Murley's Branch, Allegany Co, Md
(Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Grocery

FATHER
12. Name: George Mc Elfish
13. Birthplace: Rush, Md.

MOTHER
14. Maiden name: Louise Wilson
15. Birthplace: Flintstone, Md.

16. Informant: Marie Mc Elfish
Address: 10 Mary St - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22, 1945 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland Md

18. Funeral director: John J. Hafer
Address: Cumberland Md.

19. June 22, 1945 (Date rec'd by registrar) Walter L. Bantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20, 1945, at 2:35 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5, 19.., to June 20, 1945
and that I last saw h.. alive on June 20, 1945

Immediate cause of death

	DURATION
(a) Coronary Thrombosis	2 days.
Due to: (b) Cerebral Embolism	3 yrs
Due to: (c)	
Due to: (d)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M E B Owens M.D.
M. D. or other
Address: 133 Va ave Date signed June 20 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

05649

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 160 Frederick St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany.

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 160 Frederick St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William J. McGreevy

3.(b) Social Security Number 205-07-9671

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Bridget Pangle

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1889.

8. AGE: Years	Months	Days	If less than one day
55	10	8	hrs. min.

9. Birthplace Barton md. (Town, county, and state)

10. Usual occupation Carman.

11. Industry or business B & O. R.R.

FATHER 12. Name Michael Mc Greevy.

13. Birthplace Ireland.

MOTHER 14. Maiden name Anna Foster

15. Birthplace md.

16. Informant Mrs. Mary Shuck.

Address Cumberland md.

17. Burial Date thereof 6/11/45 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Patricks Cem.

Location Cumberland md.

18. Funeral director Louis Stein Inc.

Address Cumberland md.

19. 6/11/45 19 Winter R. Frantz M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1945 at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1945, to June 8 1945 and that I last saw h... alive on June 8 1945

Immediate cause of death	DURATION
Hypostatic Pneumonia	
Due to Cerebral Embolism	
Due to Coronary Sclerosis & Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Barclay Hunter M.D. M. D. or other

Address Cumberland md. Date signed 6/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

05650

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Years

Hospital, institution, or street address where death occurred: Sylvan Retreat

How long in hospital or institution? 4 Years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Barton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Hugh McManus

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE:

Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: Barton - Allegany - Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Coal Mine

FATHER — 12. Name: Thomas McManus

13. Birthplace: Scotland

MOTHER — 14. Maiden name: Jane McCutheon

15. Birthplace: Scotland

16. Informant: Geo. McManus

Address: Longacoming. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 30 1945 (month) (day) (year)

Cemetery or crematory: Laurel Hill

Location: Mosser, Md.

18. Funeral director: Ellsworth & Bral

Address: Westernport, Md.

19. June 27 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

29. DATE OF DEATH: June 27 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 14 1944 to June 27 1945

and that I last saw him alive on June 23 1945

Immediate cause of death	DURATION
Chronic Myocardial Degeneration	
Due to Generalized Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: June 27 1945

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

15651

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY COUNTY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State PENNA. County SOMERSET
City or town ROCKWOOD (If outside city or town limits, write RURAL and give nearest town)
Street No. 741 ROCKWOOD ST. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME MR. ARTHUR A. MILLER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife OLIVE BIRD
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) JANUARY 2, 1899

8. AGE: Years	Months	Days	If less than one day
46	5	5	..... hrs. ..... min.

9. Birthplace PENNA. (Town, county, and state)
10. Usual occupation MERCHANT
11. Industry or business

FATHER
12. Name EDWARD E. MILLER
13. Birthplace PENNA.

MOTHER
14. Maiden name ADA CRITCHFIELD
15. Birthplace PENNA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10, 1945 (month) (day) (year)
Cemetery or crematory I.O.O.F. Cemetery
Location Rockwood, Pa.
18. Funeral director John Gilbert Jr.
Address Cumberland, Md.

19. June 8, 1945 (Date rec'd by registrar) Walter L. Mauk, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 7, 45 11:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 6, 1945 to JUNE 7, 1945 and that I last saw h 1m alive on JUNE 7, 1945

	DURATION
Immediate cause of death Uremia	2
Phlebitis Rt. Leg	2
Acute Myocardial Insuf.	15
Coronary Artery Thrombosis	2
Hypertensive Vascular Dis.	3
Due to Anuria	1 day
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Russell Jacobson M. D. or other
Address 15 S. Liberty St. Date signed 6/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63)

CERTIFICATE OF DEATH

Reg. Dist. No. 9 — 05652

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ALLEGANEY
City or town: FROSTBURG MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MINERS HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: GARRETT
City or town: GRANTSVILLE, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: KEYSERS RIDGE
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: CARL EVERETT MILLER

3. (b) Social Security Number: 216-07-8505

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of ~~husband~~ or wife: CARRIE MAGARET MILLER
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): JUNE - 18 - 1901

8. AGE: Years	Months	Days	If less than one day
43	11	14	..... hrs. ..... min.

9. Birthplace: GRANTSVILLE GARRETT, MD. (Town, county, and state)
10. Usual occupation: CREAMERY (DAIRY)
11. Industry or business

FATHER
12. Name: CLARENCE C MILLER
13. Birthplace: GRANTSVILLE MD.

MOTHER
14. Maiden name: CATHERINE M. HANET
15. Birthplace: KEYSERS RIDGE, GARRETT CO. MD.

16. Interment: CARRIE MAGARET MILLER
Address: GRANTSVILLE, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: JUNE 4 1945 (month) (day) (year)
Cemetery or ~~crematory~~: GRANTSVILLE
Location: GRANTSVILLE MD.

18. Funeral director: WM. WINTERBERG
Address: GRANTSVILLE, MD

19. 6-4 19 45 Mrs. Nancy A. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2 19 45 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15- 19 45- to June 2 19 45- and that I last saw him alive on June 1 19 45-

Immediate cause of death	DURATION
Acute thyrotoxicosis	3 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: X Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other
Address: Frostburg, Md. Date signed: 6/4/45-

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47d)

CERTIFICATE OF DEATH

05653

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred: 847 Leiphart Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Alleg.

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 847 Leiphart Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Catherine Miller

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widow

6.(b) Name of husband or wife: William Miller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 12 1881

8. AGE: Years	Months	Days	If less than one day
64	3	17	..... hrs. ..... min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: Patrick Kelley

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Martha Dressing

MOTHER — 15. Birthplace: Cumberland Md.

16. Informant: Leo W. Miller

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 2 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland, Md.

18. Funeral director: Louis Stein Sons

Address: Cumberland Md

19. June 30 1945 (Date rec'd by registrar) Wister R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1945, to June 29 1945

and that I last saw her alive on June 28 1945

Immediate cause of death: Carcinoma pulmonary,	DURATION
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. Wister M. D. or other

Address: 121 Bedford St. Date signed: 6/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-2)

05654

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred
Allegany Hospital

How long in hospital or institution? 17 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Near Cumberland (If outside city or town limits, write RURAL and give nearest town) Rural

Street No. Bowling Green
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lewis Curtis Millholland.

3. (b) Social Security Number 216-18-1127

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Minnie West.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 23, 1875

8. AGE:	Years	Months	Days	If less than one day
	70	2	11	..... hrs. ..... min.

9. Birthplace Mt Savage - md.
(Town, county, and state)

10. Usual occupation

11. Industry or business Sand Company.

MOTHER FATHER

12. Name James A. Millholland

13. Birthplace Unknown

14. Maiden name Virginia Keim

15. Birthplace Unknown

18. Informant Beverley Millholland

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. June 6, 1945 Winter L. Beatty, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1945, at 9-40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28, 1945, to June 4, 1945, and that I last saw him alive on June 4, 1945

Immediate cause of death Uremia.

DURATION 7 Days

Due to Acute Nephritis and enlarged Prostate.

Due to Alcoholism. C.V.D.

Other conditions Only treated for a short time. Unable to obtain history.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. P. W. Snyder M. D. or other

Address 36 Green St. Date signed 6-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

056559
Reg. Dist. No. 9

VS A15 — MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: R F D 2, Frostburg, Md
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R F D 2 Box 140
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Elmer Minnick
3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 26 1940

8. AGE: Years: 4 | Months: 7 | Days: 0 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frostburg Allegany City, Md
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Marion Minnick
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mildred Jeffries
15. Birthplace: Maryland

16. Informant: Mrs. Marion Minnick
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28, 1945 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg Md.

18. Funeral director: J. J. Durst
Address: Frostburg Md.

19. 6-27 (Date rec'd by registrar) 19 45 Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 19 45 at 11:59 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 44 to June 25 19 45
and that I last saw h. i. m. alive on June 25 19 45

Immediate cause of death	DURATION
Congenital valvular heart disease.	Since age 6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other
Address: Frostburg, Md. Date signed 6/27/45

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1454

05656

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55. Years

Hospital, institution, or street address where death occurred:
Collins Convalescent Home

How long in hospital or institution? 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 505. Decatur St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Kate Esther Mitchell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: James W. Mitchell

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 24 1860

8. AGE: Years	Months	Days	If less than one day
84	8	1	..... hrs. ..... min.

9. Birthplace: Hillsboro, North Carolina
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: Own House

FATHER
12. Name: Thomas V. White
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Mary E. Pleasant
15. Birthplace: Hillsboro. N. C.

16. Informant: George E. Mitchell

Address: 117. Independence St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 28 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. June 28 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 1945 at 4-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1945 to June 25 1945 and that I last saw h.. alive on June 22 1945

Immediate cause of death	DURATION
Cancer of the stomach	2 Yrs
Due to:	
Due to:	
Other conditions: cachexia	1/2 Yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other

Address: [illegible] Date signed: 6-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-G)

CERTIFICATE OF DEATH

05657

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Allegany Hospital Cumberland Md.
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 322 N. Mechanic St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lulu Mulligan

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife Walter Mulligan
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 26th 1882

8. AGE: Years	Months	Days	If less than one day
62	7	6.	..... hrs. ..... min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Private Home
FATHER 12. Name Anthony Lehman
13. Birthplace Maryland.
MOTHER 14. Maiden name Elizabeth Coleman
15. Birthplace Maryland.
16. Informant Walter Mulligan
Address Cumberland Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6 1945 (month) (day) (year)
Cemetery or crematory Mt Zion Cem.
Location Cumberland Md. Rt-40
18. Funeral director Louis Stein Inc.
Address Cumberland Md.
19. June 6 1945 (Date rec'd by registrar) Winter L. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4 1945 at 8:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1-43 19.. to 6-4-45 19.45
and that I last saw h.. alive on 6-3-45 19..

Immediate cause of death	DURATION
Carcinoma Uteres	2 yrs.
Due to	
Due to	
Carcinomatosis	3 mo.
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. C. Lemmon M. D. or other
Address Cumberland Md. Date signed 6-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-M)

CERTIFICATE OF DEATH

05658

Reg. Dist. No. ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (rural)

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 minutes

Hospital, Institution, or street address where death occurred: R.F.D. 2.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland (rural)

(If ontside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. 2. (Murley's Branch)

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Carolyn Louise Nazelrod

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 30, 1945

8. AGE: Years	Months	Days	If less than one day
—	—	—	— hrs. 20 min.

9. Birthplace: Cumberland, Allegany Co, Md. R.F.D. 2. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Walter V. Nazelrod
13. Birthplace: Hardy Co., W. Va.

MOTHER
14. Maiden name: Maude L. Stallings
15. Birthplace: Allegany Co., Md.

16. Informant: Walter V. Nazelrod

Address: Cumberland, Md. R.F.D 2,

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 30 1945 (month) (day) (year)

Cemetery or crematory: Mt. Tabor

Location: Spring Gap, Md.

18. Funeral director: John D. Haber

Address: Cumberland Md.

19. ... 19... (Date rec'd by registrar) Nina Bender Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1945, at 1.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1945, to June 30 1945 and that I last saw h.r. alive on June 30 1945

Immediate cause of death	DURATION
Complete determination of Limbs and Body	
Due to	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: J. A. Watson M.D. M. D. or other

Address: Lot's Choice Md. Date signed: June 30 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

05659

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 yrs.
Hospital, Institution, or street address where death occurred:
719 N Mechanic St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 719 N Mechanic St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lucy Mathilda Gree

3.(b) Social Security Number None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: John S Gree
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): July 12 1870
8. AGE: Years 74 | Months 11 | Days 9 | If less than one day ..... hrs. ..... min.
9. Birthplace: Cumberland Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Bernard O'Donnell
13. Birthplace: Va.
MOTHER 14. Maiden name: Mary Broderick
15. Birthplace: Ireland.
16. Informant: Mrs Helen A Brode
Address: Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15 '45 (month) (day) (year)
Cemetery or crematory: St Peter & Pauls Cem
Location: Cumberland.
18. Funeral director: Louis Stein Inc.
Address: Cumberland.
19. June 14 19 45 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14 19 45 at 10:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/9 19 45, to 6/12 19 45 and that I last saw h[illegible] alive on 6/21 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	4 days
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Elizabeth Bragg M.D.
M. D. or other
Address: Loup, Md. Date signed 6/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

*15660

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years

Hospital, Institution, or street address where death occurred:
Enroute to Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 13 N. Waverly Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war World War II

3. (a) FULL NAME Harry Crispin Oglebay

3. (b) Social Security Number 165-09-9906

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife Hazel Rogers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1903

8. AGE: Years	Months	Days	If less than one day
41	6	26	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation Machinist helper

11. Industry or business B. & O. R. R.

FATHER 12. Name Harry C. Oglebay

13. Birthplace Cumberland, Md.

MOTHER 14. Maiden name Alice E Balows

15. Birthplace Adamstown, Md

16. Informant Ebis Oglebay Pub X

Address 13 N. Waverly Terrace.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland

18. Funeral director John J. Hafer

Address Cumberland, Md

19. June 10, 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results no Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Prince H. Bowson M. D.
M. D. or other

Address Cumberland, Maryland Date signed 6-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-C)

CERTIFICATE OF DEATH

05661

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 JAMES STREET
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ETHEL E. O'REAR

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: JOHN W. O'REAR
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): OCT. 27 1894

8. AGE: Years	Months	Days	If less than one day
51	7	14	....hrs. ....min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at Home.

FATHER
12. Name: JOHN W. COX
13. Birthplace: W.VA.

MOTHER
14. Maiden name: EFFIE KNIGHT
15. Birthplace: MARYLAND

16. Informant: John H O'Rear
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 13 45 (month) (day) (year)
Cemetery or crematory: Philos Cem.
Location: Westernport Md
18. Funeral director: Louis Stein Inc.
Address: Cumberland

19. June 13, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JUNE 11 1945 at 7:07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945 to June 11 1945 and that I last saw h.... alive on June 11 1945

Immediate cause of death	DURATION
Cardiac Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. O'Leary M.D. M. D. or other
Address: 49 Greene St. Date signed: 6/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

05662

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Janette Caroline Orr

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William E. Orr, Sr.
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): Aug 24, 1892

8. AGE:

Years	Months	Days	If less than one day
52	10	3	hrs. min.

9. Birthplace (town, county, and state): Blantage Lanarkshire Co. Scotland
10. Usual occupation: Domestic
11. Industry or business: Own home

FATHER
12. Name: James Speis
13. Birthplace: Scotland

MOTHER
14. Maiden name: Annie Smith
15. Birthplace: Scotland

16. Informant: Wm. E. Orr, Sr.
Address: Lonaconing, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) July 2 1945
Cemetery or crematory: Oak Hill Cem.
Location: Lonaconing, Md.

18. Funeral director: Mrs. Lavy Boal Berry
Address: Westernport, Md.

19. June 30 1945 (Date rec'd by registrar) W. E. Orrington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29, 1945, at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1945, to June 29, 1945
and that I last saw h.. alive on June 29, 1945

Immediate cause of death	DURATION
Cancer of Intestines	
Due to (Colon) and Liver	1 mo
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Cancer
Date of op. Apr. 8-1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. E. Orrington M. D. or other
Address: Lonaconing Date signed 6/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-c

CERTIFICATE OF DEATH

05663

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital, Cumberland Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Frederick St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Paul, Mrs. Mona

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John Paul

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 16 1883

8. AGE: Years	Months	Days	If less than one day
61	9	2	..... hrs. ..... min.

9. Birthplace Romney W. Va.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Frank Inglney.

13. Birthplace W. Va.

MOTHER 14. Maiden name Mollie Lynchicomb

15. Birthplace W. Va.

16. Informant John Paul.

Address Cumberland.

17. Burial (Burial, cremation, or removal) Which?) Date thereof June 16 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumberland.

18. Funeral director Louis Stein Inc

Address Cumberland

19. June 15 19 45 (Date rec'd by registrar) Wilbur R. Trail M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/14 1945 at 11:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1945, to June 14, 1945 and that I last saw h... alive on June 14, 1945

Immediate cause of death	DURATION
Arteriosclerosis	2 yrs.
Due to Cerebral Hemorrhage	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Clay S. Jones M. D. or other

Address Cumberland Date signed 6-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

05664

★ 10 Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Elizabeth Porter

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 19 - 1876

8. AGE: Years	Months	Days	If less than one day
68	9	4	..... hrs. ..... min.

9. Birthplace: Mt Savage Alley - Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Jacob Porter

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary McGrogan

MOTHER — 15. Birthplace: Scotland

16. Informant: Mrs Chas Norman

Address: Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26-1945 (month) (day) (year)

Cemetery or ~~crematory~~: St. Patricks

Location: Mt. Savage

18. Funeral director: J J Quinn

Address: Frostburg, Md.

19. 6/25 (Date rec'd by registrar) 1945 Vernon McDermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23rd 1945 at 8:.. P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 1945, to June 22 1945

and that I last saw h[illegible] alive on June 22 1945

Immediate cause of death	DURATION
Medical Report Later	Several years -
Due to	
Due to Fracture due to accidental fall. C.V.D.	
Other conditions Myocarditis & Fracture Avulsion neck of Femur -	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of May 20th 1945

Where did injury occur? (City or town) (County) (State)

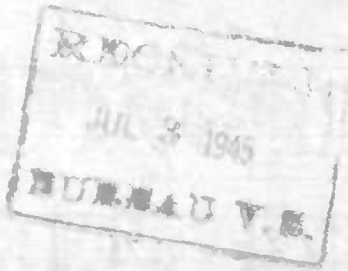
Injured at home, farm, industry, public place (where?) At home

Means of injury Injured at work?

23. SIGNATURE: William E. Moseley M. D.

M. D. or other

Address: Mt Savage Md. Date signed 6/24-45


JUL 3 1945
U.S.

DR. GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125)

CERTIFICATE OF DEATH

T 05665

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 DAYS

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MD. County ALLEGANY

City or town CUMBERLAND, MD. (If outside city or town limits, write RURAL and give nearest town)

Street No. 703 LEIPER ST. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR SAMUEL ROBINETTE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MRS. RUTH HITE 6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) OCT. 22, 1875

8. AGE: Years	Months	Days	If less than one day
69	7	13	hrs. min.

9. Birthplace MD. ALLEGANY County (Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

FATHER — 12. Name Gillus Robinette

13. Birthplace Maryland

MOTHER — 14. Maiden name Sarah Irons

15. Birthplace Maryland

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6, 1945 (month) (day) (year)

Cemetery or crematory Davis Memorial

Location OldTown Road

18. Funeral director Charles L. George

Address Cumberland, Md.

19. June 6, 45 (Date rec'd by registrar) Walter R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 4 1945 at 12:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-31-45 19 to 6-4 19 45 and that I last saw him alive on 6-3 19 45

Immediate cause of death	DURATION
Strangulated Left inguinal hernia	2 hours
Due to	
Due to	
Other conditions Hypertension - Arteriosclerosis	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations Strangulated omentum Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. or other

Address [illegible] Date signed 6-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

115666

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants, give residence of mother)
State: Maryland County: Allegany
City or town: Harpersville — Near Middle Ridge Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
John Savage

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances Conway
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Aug. 4, 1877

8. AGE: Years	Months	Days	If less than one day
67	10	7	hrs. min.

9. Birthplace: Barton, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Coal Mining
11. Industry or business: Jos. Nichol Coal Mine
FATHER 12. Name: Edwin Francis Savage
FATHER 13. Birthplace: Barton, Md.
MOTHER 14. Maiden name: Cook
MOTHER 15. Birthplace: Dunkenwon
16. Informant: Mrs. John Savage
Address: Harpersville, Near Middle Ridge Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md
18. Funeral director: Mr. Eichhorn
Address: Lonaconing, Md
19. 6-12 1945 Mrs. Nancy L. Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945, at 6 1/4 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1945, to June 11 1945
and that I last saw him alive on June 10 1945
Immediate cause of death: Chronic Myocarditis

DURATION
Several months

Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: W. M. Lane M.D.
Address: Frostburg Md M. D. or other
Date signed: June 11 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05667

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 yrs.
Hospital, institution, or street address where death occurred: 26 Spring St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 26 Spring St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Karl Ernst Schlessstein

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Magdalena Berger
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan - 12 - 1867

8. AGE: Years 78 | Months 5 | Days 5 | If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Manager of Brewery
FATHER 12. Name: Karl Schlessstein
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Marie Beckbach
MOTHER 15. Birthplace: Germany
16. Informant: Miss Irma Schlessstein
Address: 26 Spring St. Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-21-1945 (month) (day) (year)
Cemetery or crematory: Allegany
Location: Frostburg, Md.
18. Funeral director: Jacob Baker
Address: Frostburg, Md.
19. 6-21 1945 (Date rec'd by registrar) Mc. Nancy A. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1945, at 11 A.M.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Jan. 1945 to June 17 1945 and that I last saw him alive on June 16 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Several months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. D. McCune M.D. M. D. or other
Address: Frostburg Md. Date signed: 6-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 157 Bowery St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 157 Bowery
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Samuel E. Smith
3.(b) Social Security Number: none

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Mary J. Smith
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): July 7, 1862
8. AGE: Years: 82 Months: 11 Days: 2 If less than one day ..... hrs. ..... min.
9. Birthplace: Gloucester England
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Coal mines
FATHER 12. Name: Alfred Smith
13. Birthplace: England
MOTHER 14. Maiden name: Martha Sanders
15. Birthplace: England
16. Informant: Mary Smith
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13-1945 (month) (day) (year)
Cemetery or crematory: Allegheny Cemetery
Location: Frostburg, Md.
18. Funeral director: J. J. Durst
Address: Frostburg Md.
19. 6-13 1945 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1945, at 4:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1945, to June 10 1945
and that I last saw him alive on June 10 1945
Immediate cause of death: Chronic Myocarditis — DURATION: 1 yr.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: W. M. McLane M.D.
M. D. or other
Address: Frostburg Md. Date signed: June 12 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

05669

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Miners hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostbrug
(If outside city or town limits, write RURAL and give nearest town)
Street No. 87 W. Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: PATRICK JOSEPH STANTON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine Stanton
6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.): March 12, 1871

8. AGE: Years	Months	Days	If less than one day
74	3	8	hrs. min.

9. Birthplace: Madison, Lake County, Ohio.
(Town, county, and state)
10. Usual occupation: Inspector
11. Industry or business: Coal mines

FATHER
12. Name: Thomas Stanton.
13. Birthplace: Ireland

MOTHER
14. Maiden name: Winifred Derrig
15. Birthplace: Ireland

16. Informant: Mrs. Patrick Stanton.
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23, 1945 (month) (day) (year)
Cemetery or crematory: St. Michael's Cemtery.
Location: Frostburg, Md.

18. Funeral director: J. J. Durst.
Address: Frostburg, Md.

19. 6-22 1945 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1945 at 2 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1945 to June 21 1945 and that I last saw h[illegible] alive on June 21 1945

	DURATION
Immediate cause of death: Arteriosclerosis	Several years
Due to:	
Due to: Chr Myocarditis	Several years
Other conditions: Gangrene Rt Leg (Include pregnancy within 3 months of death)	2 wks

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane M.D. M. D. or other
Address: Frostburg Md Date signed 6-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05670

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hrs.
Hospital, Institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 2hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penn. County: Allegheney
City or town: McKeesport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2910 Stewart St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles J. Steelberg

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w.	Widowed

6.(b) Name of husband or wife: Louise Reffler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 8. 1863

8. AGE: Years	Months	Days	If less than one day
82	-	7	..... hrs. ..... min.

9. Birthplace: Sweden (Town, county, and state)
10. Usual occupation: Puddler – Retired
11. Industry or business: Steel Mills

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Walter Steelberg
Address: Mc Keesport, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19 1945 (month) (day) (year)
Cemetery or crematory: Penn Memorial
Location: McKeesport, Pa.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md

19. June 15 19 45 (Date rec'd by registrar) Winter R. Hauntz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15th., 19 45 at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Thrombosis	1 hr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op. .....
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: (1) Bruce H. Brown, M.D.
Address: Cumberland, Maryland M. D. or other
Date signed: 6-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

05671

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74. Years

Hospital, institution, or street address where death occurred: 414. Magruder St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 414. Magruder St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Karl W. F. Stuiber

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Harriett Stuiber

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): October 1 1868

8. AGE: Years	Months	Days	If less than one day
76	8	1	...hrs. ...min.

9. Birthplace: Hamburg, Germany (Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business: Makeing Mens Suits

FATHER

12. Name: George Stuiber

13. Birthplace: Germany

MOTHER

14. Maiden name: Whilimenia Geseka

15. Birthplace: Berlin, Germany

16. Informant: Mrs. Karl W. F. Stuiber

Address: Magruder St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 4, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Mausoleum

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. June 4 1945 (Date rec'd by registrar) Winter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2, 1945 at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1945, to June 2, 1945; and that I last saw him alive on June 1, 1945

Immediate cause of death	DURATION
Arteriosclerosis	4 yrs.
Cerebral Hemorrhage	2 yrs.
Due to: Uraemia	10 Days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: Chas J. Stuiber M. D. or other

Address: Cumberland Date signed: June 2, 1945

Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

05672

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred: 406 Pulaski St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 406 Pulaski St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Laura Anna Thompson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Chas E. Thompson

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Dec 8, 1873

8. AGE:

Years	Months	Days	If less than one day
71	5	26	...hrs. ...min.

9. Birthplace Flintstone Allegany Co., Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

MOTHER FATHER

12. Name James M. Buley

13. Birthplace Shokane N. Y.

14. Maiden name Julia Diehl

15. Birthplace Shaneysville Pa

16. Informant Mrs. Chas E. Thompson

Address 406 Pulaski St Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Md

18. Funeral director John J. Hafer

Address Cumberland Md.

19. June 7 1945 Winter R. Beanty M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1945 at 9:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4. 26. 1943 to June 4 1945

and that I last saw her alive on 6-4- 1945

	DURATION
Immediate cause of death Coronary Occlusion	4
Due to Arteriosclerosis	Yrs.
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 6-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

05673

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Christie Rd – R F D # 4
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Christie Rd R F D # 4
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Anna Elizabeth Frasier

3. (b) Social Security Number None

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Jonas Frasier
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) July 2, 1872
8. AGE: Years 72 Months 11 Days 9 If less than one day ..... hrs. ..... min.
9. Birthplace Pa (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John Christopher Pfeiffer
13. Birthplace Germany
MOTHER 14. Maiden name Elizabeth Dahl
15. Birthplace Germany
16. Informant Ed & Wagner
Address Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13 '45 (month) (day) (year)
Cemetery or crematory Cooks Mill Cem.
Location Cooks Mill Pa.
18. Funeral director Louis Stein Inc.
Address Cumberland
19. June 13 1945 White F Beauty M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1945, at 3:20 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 29 1944 to June 12 1945 and that I last saw her alive on June 12 1945
Immediate cause of death 1. Carcinoma of Uterus — DURATION: more than 18 mos.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Charlotte B. Gardner M D
M. D. or other
Address Cumberland Md. Date signed 6/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

CERTIFICATE OF DEATH

05674

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? — 75 yrs

Hospital, Institution, or street address where death occurred: 722 No. Centre St

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Alleg.

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 722 No Centre St. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Sarah Ellen Tyler

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: George W. Tyler

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 9. 1878

8. AGE:

Years	Months	Days	If less than one day
66	8	5	..... hrs. ..... min.

9. Birthplace: Pa (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: House

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: "

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: "

16. Informant: Geo. R. Tyler

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 17 1945 (month) (day) (year)

Cemetery or crematory: Summers Cem

Location: Cumberland Md

18. Funeral director: Louis Steva Sons

Address: Cumberland Md

19. June 15, 1945 (Date rec'd by registrar) Winter F. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14 1945, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1st 1944, to June 14, 1945

and that I last saw h. alive on June 10 1945

Immediate cause of death: Carcinoma of the cervix — DURATION: 18 mo

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Geo O Faulkner M. D. or other

Address: 195 Liberty St. Date signed: 6/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

T 05675 9

Reg. Diat. No.

1. PLACE OF DEATH: Allegany

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution, or street address where death occurred: Miner's Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 13 Grant St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Voghtman

3. (b) Social Security Number 220-10-4469A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Wagner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6 - 1871

8. AGE:

Years	Months	Days	If less than one day
73	11	5	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Shoemaking

11. Industry or business: Cabinet Shop.

FATHER

12. Name: Conrade Voghtman

13. Birthplace: Germany

MOTHER

14. Maiden name: Catherine Krug

15. Birthplace: Germany

16. Informant: Adam Voghtman

Address: Front St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-14-1945 (month) (day) (year)

Cemetery or crematory: German Lutheran

Location: Frostburg, Md.

18. Funeral director: Jacob Walter

Address: Frostburg, Md.

19. 6-12-45 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945, at 10 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 4 1945, to June 11 1945; and that I last saw h. I'M alive on June 11 1945.

	DURATION
Immediate cause of death: Cerebral hemorrhage	8 days.
Due to: Hypertensive Cardio vascular disease	
Due to: Arterio-sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other

Address: Frostburg, Md. Date signed 6/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1574)

CERTIFICATE OF DEATH

05676

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 night

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Midlothian (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Baby Walker

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 28-1945

8. AGE: Years: 0 | Months: 0 | Days: 8 | If less than one day: ... hrs. ... min.

9. Birthplace: Midlothian - Alleg - Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Geo W Walker

13. Birthplace: Midlothian

MOTHER — 14. Maiden name: Lillian Saylor

15. Birthplace: Md.

16. Informant: Geo Walker

Address: Midlothian

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5-1945 (month) (day) (year)

Cemetery or ~~crematory~~: Allegany

Location: Frostburg, Md.

18. Funeral director: J. E. Deely

Address: Frostburg Md

19. 6-5 1945 Mildred A Rice (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 1945 at 5 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1945, to June 5 1945 and that I last saw h... alive on June 5 1945

Immediate cause of death	DURATION
Congenital Heart	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W M Lane M.D. M. D. or other

Address: Frostburg Md Date signed: June 5 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

05677

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: allegany
City or town: near — Borden Shaft
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md — County: allegany
City or town: midlothian
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Walker

3.(b) Social Security Number: 213-05-7117

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Janet Walker
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec 18 — 1876
8. AGE: Years 68 — Months 5 — Days 25 — If less than one day ... hrs. ... min.
9. Birthplace: Scotland (Town, county, and state)
10. Usual occupation: coal miner
11. Industry or business

FATHER
12. Name: Wm Walker
13. Birthplace: Scotland

MOTHER
14. Maiden name: Agnes Spiers
15. Birthplace: Scotland

16. Informant: Wm Walker
Address: Smith coach, Pa.

17. Burial (Burial, cremation, or removal, Which?) — Date thereof: June 15-1945 (month) (day) (year)
Cemetery or ~~crematory~~: allegany
Location: Frostburg md
18. Funeral director: J J Durst
Address: Frostburg md

19 6-13 45 (Date rec'd by registrar) — Mrs. Nancy N. Roe, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12th., 1945 at 2.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary Occlusion — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: ---
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: James H. Dorsey M.D. (M. D. or other)
Address: Cumberland, Maryland — Deputy Medical Examiner — Date signed 6-12-45

Dr Durrett

T 15678

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

VS A15 (T) (1) (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, Institution, or street address where death occurred: 213 Pennsylvania Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 213 Pennsylvania Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Adron Warnick

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mae Plummer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 26, 1871

8. AGE: Years 74 | Months 1 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Barton Allegany Co. Md (Town, county, and state)

10. Usual occupation Retired Freight Conductor

11. Industry or business B. & O Railroad

FATHER 12. Name Samuel Warnick

13. Birthplace Barton, Md.

MOTHER 14. Maiden name Anna Musser

15. Birthplace Barton, Md.

16. Informant Chas Warnick

Address 213 Pa. Ave - Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5, 1945 (month) (day) (year)

Cemetery or crematory Knights of Pythias

Location Newburg W. Va.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. June 4, 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2, 1945, to June 2, 1945 and that I last saw him alive on June 1, 1945

Immediate cause of death Coronary Thrombosis

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas R. Jones M. D. or other

Address Cumberland Date signed June 4, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05679

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Yrs.

Hospital, institution, or street address where death occurred: 412 Park St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 412 Park St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles A. Wigal

3.(b) Social Security Number: 705-05-1802

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Thelma Echales Wigal

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 27, 1875

8. AGE:	Years	Months	Days	If less than one day
	70	3	10	..... hrs. ..... min.

9. Birthplace: Parkersburg, W. Va. (Town, county, and state)

10. Usual occupation: Retired Supt. Of Water

11. Industry or business: B. & O. R.R. Co.

FATHER — 12. Name: John Wigal

FATHER — 13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Elizabeth Stevens

MOTHER — 15. Birthplace: W. Va.

16. Informant: Mrs. Thelma Wigal

Address: 412 Park St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 15, 1945 (month) (day) (year)

Cemetery or crematory: HillCrest Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. June 15 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13th., 1945, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thomas H. Dotson, M.D.

M. D. or other

Address: Cumberland, Maryland Date signed: 6-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★05680

Reg. Diat. No. 1

1. PLACE OF DEATH:

County: Allegany

City or town: Little Orleans (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred: R.F.D. 1,

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Little Orleans (If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. 1, (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edith Wigfield

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Clem A. Wigfield

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1894

8. AGE:

Years	Months	Days	If less than one day
50	9	7	— hrs. — min.

9. Birthplace: Buck Valley, Fulton Co., Pa. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Own home

FATHER
12. Name: George Sigel
13. Birthplace: Fulton Co. Pa.

MOTHER
14. Maiden name: Hulda Belle Redinger
15. Birthplace: Bedford Co. Pa.

16. Informant: Grayson Wigfield
Address: 216 W. Wilson Blvd. Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 20, 1945 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Buck Valley, Pa.

18. Funeral director: Charles A. Bast

Address: Hancock, Md.

19. June 19. 1945 (Date rec'd by registrar) T. T. Mann per M.E. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1945, at 5:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1945, to June 16 1945

and that I last saw her alive on June 16 1945

Immediate cause of death	DURATION
Carcinoma of liver and gall bladder	9 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. A. Watson, M.D. M. D. or other

Address: Little Orleans Md. Date signed: June 19, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-C)

CERTIFICATE OF DEATH

05681

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital, Cumberland Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 141 N. 3rd St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Wilson, Anthony

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10 - 15 - 1944

8. AGE:

Years	Months	Days	If less than one day
	7	30	hrs. ..... min.

9. Birthplace: Cumberland Allegany, Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Ralph Wilson

13. Birthplace: Cumberland Md

MOTHER

14. Maiden name: Mary Passalles

15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Ralph Wilson

Address: 141 W 3rd St. Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16, 1945 (month) (day) (year)

Cemetery or crematory: St. Mary's Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. June 15 1945 (Date rec'd by registrar) Winter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/14, 19 45, at 12:01 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-15 1944, to 6-14 1945

and that I last saw h[illegible] alive on 6-14 1945

Immediate cause of death: Hydrocephalus — Duration: 4 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Hydrocephalus

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Solomon Jr. M.D. M. D. or other

Address: Cumberland Md Date signed: 6-14-45